State: *Arkansas* ***Filing Company:*** *The Chesapeake Life Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2012 CLICO DR APP*
Project Name/Number: *2012 ANCILLARY APP/CH-26109-APP (09/12)*

Filing at a Glance

Company:	The Chesapeake Life Insurance Company
Product Name:	2012 CLICO DR APP
State:	Arkansas
TOI:	H21 Health - Other
Sub-TOI:	H21.000 Health - Other
Filing Type:	Form
Date Submitted:	08/16/2012
SERFF Tr Num:	MGCC-128556603
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	CH-26109-APP (09/12)
Implementation Date Requested:	On Approval
Author(s):	Lavonda English, Kim Perkins
Reviewer(s):	Rosalind Minor (primary)
Disposition Date:	09/21/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** The Chesapeake Life Insurance Company
TOI/Sub-TOI: H21 Health - Other/H21.000 Health - Other
Product Name: 2012 CLICO DR APP
Project Name/Number: 2012 ANCILLARY APP/CH-26109-APP (09/12)

General Information

Project Name: 2012 ANCILLARY APP
Project Number: CH-26109-APP (09/12)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Lavonda English

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type: Individual
Filing Status Changed: 09/21/2012
State Status Changed: 09/21/2012
Created By: Lavonda English
Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

PPACA Notes: null

Filing Description:
This form is new and not intended to replace any forms previously approved by your Department, and is similar to application form CH-26109 (04/11) that was approved by your department on June 23, 2011, under SERFF tracking number MGCC-127174546; however, we have revised the format and condensed and/or combined certain questions in an effort to simplify the application. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

This application form is intended to be used to solicit coverage under the supplemental policy forms specified on the attached "Forms Listings" page, that are marketed through various distribution channels such as agents/brokers and direct response. The "Forms Listing" document is intended to be supporting documentation only in order to assist the Department in its review.

It is our hope that we may also be granted the flexibility to solicit coverage using this application for any future submitted/approved supplemental health insurance policies. Of course, if/when this occurs, it will be appropriately noted in the respective form filing. This application will also be used in an electronic format.

The bracketed information is intended to be variable and to allow flexibility. For example, some of the variable brackets are to allow product information to be included or omitted in the insurance coverage selections and various sections of the application form should the plan marketing names and/or benefit options be changed, and to allow changes to the billing information. Please accept our assurance that at no time will any bracketed text ever be included, omitted, or changed to reflect information that is not in compliance with applicable law.

Company and Contact

Filing Contact Information

LaVonda English, Senior Compliance Analyst
9151 Boulevard 26
North Richland Hills, TX 76180

LaVonda.English@healthmarkets.com
817-255-3155 [Phone]
817-255-8153 [FAX]

State: *Arkansas* ***Filing Company:*** *The Chesapeake Life Insurance Company*
TOI/Sub-TOI: *H21 Health - Other/H21.000 Health - Other*
Product Name: *2012 CLICO DR APP*
Project Name/Number: *2012 ANCILLARY APP/CH-26109-APP (09/12)*

Filing Company Information

The Chesapeake Life Insurance Company
9151 Boulevard 26
North Richland Hills, TX 76180
(817) 255-3100 ext. [Phone]

CoCode: 61832
Group Code: 264
Group Name:
FEIN Number: 52-0676509

State of Domicile: Oklahoma
Company Type: Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation: $50.00 per form
Per Company: No

Company	Amount	Date Processed	Transaction #
The Chesapeake Life Insurance Company	$50.00	08/16/2012	61752780

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/21/2012	09/21/2012
Approved-Closed	Rosalind Minor	08/20/2012	08/20/2012

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Lavonda English	09/21/2012	09/21/2012
Supporting Document	9/21/12 redline corrections	Lavonda English	09/21/2012	09/21/2012

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Disposition

Disposition Date: 09/21/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

This submission was re-opened at the request of the company in order to correct typos to the form and replace the form with the corrections.

The filing is being approved on this date.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter & forms listing	Approved-Closed	Yes
Supporting Document	9/21/12 redline corrections	Approved-Closed	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Disposition

Disposition Date: 08/20/2012
Implementation Date:
Status: Approved-Closed
HHS Status: HHS Approved
State Review: Reviewed-No Actuary
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Cover Letter & forms listing	Approved-Closed	Yes
Supporting Document	9/21/12 redline corrections	Approved-Closed	Yes
Form (revised)	Application	Approved-Closed	Yes
Form	Application	Replaced	Yes

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Amendment Letter

Submitted Date: 09/21/2012

Comments:

Thank you for re-opening this filing. As stated in my email correspondence, Question #7 and #9 of the Application has been revised. No other changes to the Application have been made. A redline copy of the revisions are attached for your ease of reference.

Your time and attention is greatly appreciated.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CH-26109-APP (09/12)	Application/Enrollment Form	Application	Initial					CH-26109-APP _0912_ final.pdf

Supporting Document Schedule Item Changes:

User Added -Name: 9/21/12 redline corrections

Comment:

[RDLN 9-21]CH-26109-APP _0912_ final.pdf

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Form Schedule

Lead Form Number: CH-26109-APP (09/12)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1	Approved-Closed 09/21/2012	CH-26109-APP (09/12)	AEF	Application	Initial:		CH-26109-APP _0912_ final.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

☐ New Applicant ☐ Existing/Previous Policyholder

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Best Time to Call: ☐ AM ☐ PM ☐ Home ☐ Work ☐ Cell

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Common Law

SCHEDULE OF APPLICANTS

Please Print (Full Name)	Sex	Relationship	DOB	Please check below for any ***Dependent Applicant age [26] or over*** *(other than spouse)* who is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the primary Applicant for support and maintenance	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #
(1)		Primary		N/A			☐ YES ☐ NO	
(2)		Spouse		N/A			☐ YES ☐ NO	
(3)				☐			☐ YES ☐ NO	
(4)				☐			☐ YES ☐ NO	
(5)				☐			☐ YES ☐ NO	
(6)				☐			☐ YES ☐ NO	
(7)				☐			☐ YES ☐ NO	
(8)				☐			☐ YES ☐ NO	

Is the Primary Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Is the Spouse Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Does any Applicant currently have existing insurance that will be replaced if coverage applied for is issued? ☐ Yes ☐ No

L O G O
I N S E R T H E R E

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Vision Plan VSC1 *(Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Premiere Vision Plan VSP1 *(Vision Insurance Policy Form CH-26120-IP (01/12), or its state variation):*
Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Dental Plan *(Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ Gold DCG1] [☐ Silver DCS1] [☐ Bronze DCB1]]

[PPO Dental Plan *(Dental Insurance Policy Form CH-26121-IP (01/12), or its state variation):*
[☐ Basic DPB1] [☐ Premiere DPP1] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct Bundle ADBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] Applicant(s): ☐1 ☐2
(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[Complete Direct Bundle KDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] Applicant(s): ☐1 ☐2
(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [24 Month] Duration]

[Hospital Direct Bundle SDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[ProtectFit Plus Plan *(Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):*
[☐ High Option FPRH] [☐ Low Option FPRL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[HospitalFit Plus Plan *(Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):*
[☐ High Option FPIH] [☐ Low Option FPIL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[PersonalFit Plus Plan *(Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):*
[☐ High Option FPEH] [☐ Low Option FPEL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[CancerWise ECA1 *(Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
First Diagnosis Cancer Benefit Amount: [☐ $20,000] [☐ $30,000] [☐ $40,000] [☐ $50,000]]

[Critical Illness Direct CIIC *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation)*:

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]]

[Critical Accident Direct CAIC *(Critical Accidental Injury Policy Form CH-26123-IP (04/11), or its state variation):*

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Accident Disability Direct DSIC *(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Income Protection Direct DIIC *(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Hospital Confinement Direct DBIC *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*

Daily Benefit Amount: [☐ $250] [☐ $500] [☐ $750] [☐ $1,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct ACLC *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*

Maximum Accidental Injury Benefit Amount: Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000]]

[Accident Companion AGLC *(Accidental Injury Only Insurance Policy Form CH-26122-IP (01/11), or its state variation):*

[☐ Level $2,500] [☐ Level $5,000] [☐ Level $7,500] [☐ Level $10,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

If applying for [PROTECTFIT PLUS PLAN,] [CRITICAL ACCIDENT DIRECT,] [ACCIDENT DIRECT,] [ACCIDENT COMPANION,] [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 2 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦ INCOME PROTECTION DIRECT]

1. (a) Occupation/duties of Primary Applicant: _____ ☐ Blue Collar ☐ White Collar

(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant: _____ ☐ Blue Collar ☐ White Collar

If applying for [ACCIDENT DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 3 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

2. Within the past 60 days has any Applicant had any abnormal diagnostic test results or unexplained weight loss, or been advised by a Physician to have any testing or treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [COMPLETE DIRECT BUNDLE,] [HOSPITAL DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 4 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]

Family History:

3. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had any form of cancer (other than skin cancer) prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 5 -] APPLICABLE TO THE FOLLOWING PLAN ONLY:

[♦ CRITICAL ILLNESS DIRECT]

Family History:

4. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 6 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

5. Has any Applicant ever been diagnosed, received medical advice to be tested, hospitalized, treated, or been treated for melanoma, cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia or other malignant growths or tumors? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

6. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [CANCERWISE] ONLY, please proceed to [SECTION 9].

[SECTION 7 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

7. Within in the last three years, has any Applicant been prescribed medication for more than one month (other than sleep aids, contraceptives, antibiotics or any medication to treat blood pressure, cholesterol, allergies, situational depression/anxiety, migraines, ADD/ADHD, thyroid conditions or heart burn/acid reflux)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

8. Does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

9. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for ***any*** of the following:

(a) Uncontrolled cholesterol or uncontrolled blood pressure, within the last 6 months, that is not currently being controlled with medication?	☐ Yes ☐ No	(d) Kidney failure or abnormal kidney functions (excludes kidney stones), within the last 10 years?	☐ Yes ☐ No
(b) Substance abuse, bipolar, major depressive, or psychotic disorder, within the last 3 years?	☐ Yes ☐ No	(e) Diabetes (type I or II), within the last 10 years?	☐ Yes ☐ No
(c) Heart disorder or disease, heart attack, stroke or mini-stroke (including transient ischemic attack), within the last 10 years?	☐ Yes ☐ No	(f) Organ transplant	☐ Yes ☐ No

If "Yes" to any of the above, indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [HOSPITALFIT PLUS,][PERSONALFIT PLUS,][CRITICAL ILLNESS DIRECT,][HOSPITAL CONFINEMENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 8 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT] ***[♦ INCOME PROTECTION DIRECT]***

10. Has any Applicant ever been convicted of any felony activity? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

11. (a) Within the last 12 months, has the Primary Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

    (Complete if applying for Spouse)
    (b) Within the last 12 months, has the Spouse Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

12. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? $_____

    (Complete if applying for Spouse)
    (b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? $_____

13. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

14. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability *(other than pregnancy)?* ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

15. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

Please proceed to [SECTION 9].

[SECTION 9 –] APPLICABLE TO ALL PLANS

BILLING INFORMATION

Initial Payment: ☐ACH (Auth Section Required) [☐Credit Card] [☐Direct Pay] [☐Payroll Deduction]	Bill Type: ☐ACH (Auth Section Required) [☐Credit Card] [☐ Direct Bill]
☐ Individual Billing / Mode: (If applicable) ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	[☐ Payroll Deduction / Mode: (If applicable) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly]
☐ Single ☐ Primary and Spouse ☐ Primary and Child(ren) ☐ Family	Relationship of Payor to Primary Applicant: ☐ Self ☐ Parent/Guardian ☐ Other If "Other" who, and reason for such:_____
[Preferred Draft Date: _____]	[Requested Effective Date of Coverage: _____ (cannot be the 29th, 30th; or 31st of any given month)]
Premium Amount quoted [(including $[20] one-time application fee)]: $_____ Check #: _____(if collected at sale)	[Special Request(s):_____]

DECLARATIONS AND AGREEMENTS

I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) no insurance will take effect unless and until the Application is approved by the Company and the Policy is delivered to the Applicant ***while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full***.

If this application was solicited by an agent, I understand that the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage.

I understand that the [Hospital Confinement Direct Policy] [and the Income Protection Direct Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *one year* after the Effective Date of Coverage [and that the [HospitalFit Plus Policy] [and the PersonalFit Plus Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *six months* after the Effective Date of Coverage.

I further understand that these products are intended as a supplement to and not a substitute for comprehensive health insurance.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

Signed _____/_____/_____ at _____, _____
Date City State

X_____ X_____
Signature of Primary Applicant Signature of Spouse Applicant (If to be covered)

TO BE ANSWERED BY AGENT FOR AGENT SOLICITED APPLICATIONS:
Each question on this application was answered and documented by the Applicant(s) named above. ☐
-OR-
I, the Agent, certify that each question on this application was asked by me of the Applicant(s) named above, and all answers were accurately documented. ☐

X _____
Signature of Licensed Agent Print Full Name Agent Number

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/20/2012
Comments:			
Attachment(s):			
AR -APP READ.pdf Arkansas Rule and Regulation 19 26109.pdf AR-GA_1211_.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/20/2012
Bypass Reason:	This is an application filing. Please refer to the Forms Schedule Tab.		
Comments:	Please refer to Form Schedulle Tab.		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/20/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/20/2012
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/20/2012
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***	***Company Tracking #:*** *CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Satisfied - Item:	Cover Letter & forms listing	Approved-Closed	08/20/2012
Comments:			
Attachment(s):			
CH-26109-APP_0912_ Supplemental App Filing Letter.pdf CH-26109 _0912_ Forms listing.pdf			

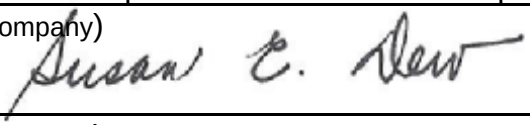
		Item Status:	**Status Date:**
Satisfied - Item:	9/21/12 redline corrections	Approved-Closed	09/21/2012
Comments:			
Attachment(s):			
[RDLN 9-21]CH-26109-APP _0912_ final.pdf			

FLESCH READABILITY CERTIFICATE

Policy or Rider Form Number	Flesch Score
CH-26109-APP (09/12)	45.4

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility and format requirements of any applicable laws and regulations in the state of Arkansas.

The Chesapeake Life Insurance Company
(Company)



(Signature)

Susan E. Dew
(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer
(Title / Department)

August 16, 2012
(Date)

Arkansas Rule and Regulation 19

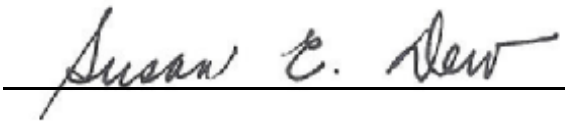
Insurer: The Chesapeake Life Insurance Company

Form Number(s):
CH-26109-APP (09/12)

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

The Chesapeake Life Insurance Company

(Company)



(Signature)

Susan E. Dew

(Printed Name)

SVP, Associate General Counsel & Chief Compliance Officer

(Title / Department)

August 16, 2012

(Date)

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws or another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);

- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders , not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

August 16, 2012

Commissioner Jay Bradford
Arkansas Department of Insurance
Life and Health Division
1200 W 3Rd ST
Little Rock, AR 72201-1904

RE: THE CHESAPEAKE LIFE INSURANCE COMPANY
NAIC#: 264-61832 FEIN#: 52-0676509

Form Number	**DESCRIPTION**
CH-26109-APP (09/12)	Application for Insurance

SERFF Tracking# MGCC-128556603

Dear Commissioner:

The above referenced application form is hereby submitted for your review and approval. This form is new and not intended to replace any forms previously approved by your Department, and is similar to application form CH-26109 (04/11) that was approved by your department on June 23, 2011, under SERFF tracking number MGCC-127174546; however, we have revised the format and condensed and/or combined certain questions in an effort to simplify the application. To the best of our knowledge, information and belief, the form submitted herewith is in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state.

This application form is intended to be used to solicit coverage under the supplemental policy forms specified on the attached **"Forms Listings"** page, that are marketed through various distribution channels such as agents/brokers and direct response. The "Forms Listing" document is intended to be supporting documentation only in order to assist the Department in its review.

It is our hope that we may also be granted the flexibility to solicit coverage using this application for any future submitted/approved supplemental health insurance policies. Of course, if/when this occurs, it will be appropriately noted in the respective form filing. This application will also be used in an electronic format.

The bracketed information is intended to be variable and to allow flexibility. For example, some of the variable brackets are to allow product information to be included or omitted in the insurance coverage selections and various sections of the application form should the plan marketing names and/or benefit options be changed, and to allow changes to the billing information. Please accept our assurance that at no time will any bracketed text ever be included, omitted, or changed to reflect information that is not in compliance with applicable law.

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

Should you need anything further in order to expedite this filing, please do not hesitate to contact me at any of the options referenced below.

Your assistance in this matter is greatly appreciated.

Sincerely,

Lavonda English
Sr. Compliance Analyst
Corporate Compliance

HealthMarkets®

9151 Boulevard 26 • North Richland Hills • TX 76180
P (817) 255-3155 • **F** (817) 255-8153
Lavonda.english@HealthMarkets.com • www.HealthMarkets.com

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

FORMS LISTING

THE CHESAPEAKE LIFE INSURANCE COMPANY

List of policy forms approved and/or pending approval by Arkansas that CH-26109-APP (09/12); et al will be used to solicit coverage under:

PREVIOUSLY APPROVED FORM	FORM TYPE	APPROVAL DATE	SERFF ID
CH-26023-IP (5/07) AR	Vision Insurance Policy	8/6/07	MGCC-126182588
CH-26055-IP (5/07) AR	Cancer Benefit Policy	5/25/07	MGCC-125182595
CH-26099-IP (1/08)	Dental Insurance Policy	4/22/08	MGCC-125612182
CH-26110-IP (06/09) AR	Accidental Injury Only Insurance Policy	7/29/09	MGCC-126242277
CH-26111-IP (06/09) AR	Hospital and Surgical Indemnity Policy	7/29/09	MGCC-126242370
CH-26112-IP (06/09) AR	Sickness-Only Scheduled Indemnity Policy	7/29/09	MGCC-126242394
CH-26113-IP (01/10) AR	Specified Disease/Condition & Major Organ Transplant Policy	1/15/10	MGCC-126418917
CH-26114-IP (01/10) AR	Accident-Only Disability Income Insurance Policy	12/16/09	MGCC-126419061
CH-26115-IP (01/10) AR	Disability Income Insurance Policy	12/16/09	MGCC-126419166
CH-26116-IP (01/10) AR	Hospital Confinement Indemnity Policy	12/16/09	MGCC-126419273
CH-26118-IP (01/10) AR	Accidental Injury Only Insurance Policy	12/16/09	MGCC-126419306
CH-26120-IP (01/12) OON AR	Vision Insurance PPO Policy	10/19/2011	MGCC-127687504
CH-26121-IP (01/12) AR	Dental Insurance PPO Policy	10/19/2011	MGCC-127687519
CH-26122-IP (01/11) AR	Accidental Injury Only Insurance Policy	6/22/2011	MGCC-127174326
CH-26123-IP (04/11) AR	Critical Accidental Injury Policy	6/20/2011	MGCC-127174356

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

☐ New Applicant ☐ Existing/Previous Policyholder

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Best Time to Call: ☐ AM ☐ PM ☐ Home ☐ Work ☐ Cell

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Common Law

SCHEDULE OF APPLICANTS

Please Print (Full Name)	Sex	Relationship	DOB	Please check below for any ***Dependent Applicant age [26] or over*** *(other than spouse)* who is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the primary Applicant for support and maintenance	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #
(1)		Primary		N/A			☐ YES ☐ NO	
(2)		Spouse		N/A			☐ YES ☐ NO	
(3)				☐			☐ YES ☐ NO	
(4)				☐			☐ YES ☐ NO	
(5)				☐			☐ YES ☐ NO	
(6)				☐			☐ YES ☐ NO	
(7)				☐			☐ YES ☐ NO	
(8)				☐			☐ YES ☐ NO	

Is the Primary Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Is the Spouse Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Does any Applicant currently have existing insurance that will be replaced if coverage applied for is issued? ☐ Yes ☐ No

L O G O
I N S E R T H E R E

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Vision Plan VSC1 *(Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Premiere Vision Plan VSP1 *(Vision Insurance Policy Form CH-26120-IP (01/12), or its state variation):*
Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Dental Plan *(Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ Gold DCG1] [☐ Silver DCS1] [☐ Bronze DCB1]]

[PPO Dental Plan *(Dental Insurance Policy Form CH-26121-IP (01/12), or its state variation):*
[☐ Basic DPB1] [☐ Premiere DPP1] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct Bundle ADBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] Applicant(s): ☐1 ☐2
(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[Complete Direct Bundle KDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] Applicant(s): ☐1 ☐2
(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [24 Month] Duration]

[Hospital Direct Bundle SDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[ProtectFit Plus Plan *(Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):*
[☐ High Option FPRH] [☐ Low Option FPRL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[HospitalFit Plus Plan *(Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):*
[☐ High Option FPIH] [☐ Low Option FPIL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[PersonalFit Plus Plan *(Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):*
[☐ High Option FPEH] [☐ Low Option FPEL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[CancerWise ECA1 *(Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
First Diagnosis Cancer Benefit Amount: [☐ $20,000] [☐ $30,000] [☐ $40,000] [☐ $50,000]]

[Critical Illness Direct CIIC *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation)*:

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]]

[Critical Accident Direct CAIC *(Critical Accidental Injury Policy Form CH-26123-IP (04/11), or its state variation):*

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Accident Disability Direct DSIC *(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Income Protection Direct DIIC *(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Hospital Confinement Direct DBIC *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*

Daily Benefit Amount: [☐ $250] [☐ $500] [☐ $750] [☐ $1,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct ACLC *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*

Maximum Accidental Injury Benefit Amount: Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000]]

[Accident Companion AGLC *(Accidental Injury Only Insurance Policy Form CH-26122-IP (01/11), or its state variation):*

[☐ Level $2,500] [☐ Level $5,000] [☐ Level $7,500] [☐ Level $10,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

If applying for [PROTECTFIT PLUS PLAN,] [CRITICAL ACCIDENT DIRECT,] [ACCIDENT DIRECT,] [ACCIDENT COMPANION,] [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 2 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦ INCOME PROTECTION DIRECT]

1. (a) Occupation/duties of Primary Applicant: _____ ☐ Blue Collar ☐ White Collar

(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant: _____ ☐ Blue Collar ☐ White Collar

If applying for [ACCIDENT DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 3 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

2. Within the past 60 days has any Applicant had any abnormal diagnostic test results or unexplained weight loss, or been advised by a Physician to have any testing or treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [COMPLETE DIRECT BUNDLE,] [HOSPITAL DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 4 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]

Family History:

3. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had any form of cancer (other than skin cancer) prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 5 -] APPLICABLE TO THE FOLLOWING PLAN ONLY:

[♦ CRITICAL ILLNESS DIRECT]

Family History:

4. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 6 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

5. Has any Applicant ever been diagnosed, received medical advice to be tested, hospitalized, treated, or been treated for melanoma, cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia or other malignant growths or tumors? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

6. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [CANCERWISE] ONLY, please proceed to [SECTION 9].

[SECTION 7 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

7. Within in the last three years, has any Applicant been prescribed medication for more than one month (other than sleep aids, contraceptives, antibiotics or any medication to treat blood pressure, cholesterol, allergies, situational depression/anxiety, migraines, ADD/ADHD, thyroid conditions or heart burn/acid reflux)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

8. Does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

9. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for ***any*** of the following:

(a) Uncontrolled cholesterol or uncontrolled blood pressure, within the last 6 months, that is not currently being controlled with medication?	☐ Yes ☐ No	(d) Kidney failure or abnormal kidney functions (excludes kidney stones), within the last 10 years?	☐ Yes ☐ No
(b) Substance abuse, bipolar, major depressive, or psychotic disorder, within the last 3 years?	☐ Yes ☐ No	(e) Diabetes (type I or II), within the last 10 years?	☐ Yes ☐ No
(c) Heart disorder or disease, heart attack, stroke or mini-stroke (including transient ischemic attack), within the last 10 years?	☐ Yes ☐ No	(f) Organ transplant	☐ Yes ☐ No

If "Yes" to any of the above, indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [HOSPITALFIT PLUS,][PERSONALFIT PLUS,][CRITICAL ILLNESS DIRECT,][HOSPITAL CONFINEMENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 8 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT] ***[♦ INCOME PROTECTION DIRECT]***

10. Has any Applicant ever been convicted of any felony activity? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

11. (a) Within the last 12 months, has the Primary Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

    (Complete if applying for Spouse)
    (b) Within the last 12 months, has the Spouse Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

12. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? $_____

    (Complete if applying for Spouse)
    (b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? $_____

13. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

14. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability *(other than pregnancy)?* ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

15. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

Please proceed to [SECTION 9].

[SECTION 9 –] APPLICABLE TO ALL PLANS

BILLING INFORMATION

Initial Payment: ☐ACH (Auth Section Required) [☐Credit Card] [☐Direct Pay] [☐Payroll Deduction]	Bill Type: ☐ACH (Auth Section Required) [☐Credit Card] [☐ Direct Bill]
☐ Individual Billing / Mode: (If applicable) ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	[☐ Payroll Deduction / Mode: (If applicable) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly]
☐ Single ☐ Primary and Spouse ☐ Primary and Child(ren) ☐ Family	Relationship of Payor to Primary Applicant: ☐ Self ☐ Parent/Guardian ☐ Other If "Other" who, and reason for such:_____
[Preferred Draft Date: _____]	[Requested Effective Date of Coverage: _____ (cannot be the 29th, 30th; or 31st of any given month)]
Premium Amount quoted [(including $[20] one-time application fee)]: $_____ Check #: _____(if collected at sale)	[Special Request(s):_____]

DECLARATIONS AND AGREEMENTS

I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) no insurance will take effect unless and until the Application is approved by the Company and the Policy is delivered to the Applicant ***while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full***.

If this application was solicited by an agent, I understand that the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage.

I understand that the [Hospital Confinement Direct Policy] [and the Income Protection Direct Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *one year* after the Effective Date of Coverage [and that the [HospitalFit Plus Policy] [and the PersonalFit Plus Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *six months* after the Effective Date of Coverage.

I further understand that these products are intended as a supplement to and not a substitute for comprehensive health insurance.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

Signed _____/_____/_____ at _____, _____
Date City State

X_____ X_____
Signature of Primary Applicant Signature of Spouse Applicant (If to be covered)

TO BE ANSWERED BY AGENT FOR AGENT SOLICITED APPLICATIONS:
Each question on this application was answered and documented by the Applicant(s) named above. ☐
-OR-
I, the Agent, certify that each question on this application was asked by me of the Applicant(s) named above, and all answers were accurately documented. ☐

X _____
Signature of Licensed Agent Print Full Name Agent Number

SERFF Tracking #:	*MGCC-128556603*	***State Tracking #:***		***Company Tracking #:***	*CH-26109-APP (09/12)*

State:	*Arkansas*	***Filing Company:***	*The Chesapeake Life Insurance Company*
TOI/Sub-TOI:	*H21 Health - Other/H21.000 Health - Other*		
Product Name:	*2012 CLICO DR APP*		
Project Name/Number:	*2012 ANCILLARY APP/CH-26109-APP (09/12)*		

Superceded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
08/16/2012	Form	Application	09/21/2012	CH-26109-APP _0912_ final.pdf (Superceded)

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

☐ New Applicant ☐ Existing/Previous Policyholder

Primary Applicant Name: _____ Agent Name: _____ Agent ID #: _____
Last First MI

Applicant's Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Daytime Phone: (____) _____ Home Phone: (____) _____

Cell Phone: (____) _____ Fax Number: (____) _____

Best Time to Call: ☐ AM ☐ PM ☐ Home ☐ Work ☐ Cell

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Common Law

SCHEDULE OF APPLICANTS

Please Print (Full Name)	Sex	Relationship	DOB	Please check below for any ***Dependent Applicant age [26] or over*** *(other than spouse)* who is incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on the primary Applicant for support and maintenance	Ht.	Wt.	Tobacco or Nicotine substitute use in last 12 months?	Social Security #
(1)		Primary		N/A			☐ YES ☐ NO	
(2)		Spouse		N/A			☐ YES ☐ NO	
(3)				☐			☐ YES ☐ NO	
(4)				☐			☐ YES ☐ NO	
(5)				☐			☐ YES ☐ NO	
(6)				☐			☐ YES ☐ NO	
(7)				☐			☐ YES ☐ NO	
(8)				☐			☐ YES ☐ NO	

Is the Primary Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Is the Spouse Applicant a U.S. Citizen? ☐ Yes ☐ No
If "No," please signify if you have: ☐ Work Permit ☐ Visa (Type:_____ Exp. Date: __/__ /__)

Does any Applicant currently have existing insurance that will be replaced if coverage applied for is issued? ☐ Yes ☐ No

L O G O
I N S E R T H E R E

APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Vision Plan VSC1 *(Vision Insurance Policy Form CH-26023-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Premiere Vision Plan VSP1 *(Vision Insurance Policy Form CH-26120-IP (01/12), or its state variation):*
Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Dental Plan *(Dental Insurance Policy Form CH-26099-IP (1/08), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ Gold DCG1] [☐ Silver DCS1] [☐ Bronze DCB1]]

[PPO Dental Plan *(Dental Insurance Policy Form CH-26121-IP (01/12), or its state variation):*
[☐ Basic DPB1] [☐ Premiere DPP1] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct Bundle ADBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Accident Disability Direct] Applicant(s): ☐1 ☐2
(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [12 Month] Duration]

[Complete Direct Bundle KDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount
[Income Protection Direct] Applicant(s): ☐1 ☐2
(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):
$[500] Monthly Indemnity Benefit [30 Day] Elimination Period [24 Month] Duration]

[Hospital Direct Bundle SDBC Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[Hospital Confinement Direct] *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*
$[250] Daily Benefit Amount
[Accident Direct] *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*
$[10,000] Maximum Accidental Injury Benefit Amount
[Critical Illness Direct] *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation):*
$[5,000] Lifetime Maximum Benefit Amount]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[ProtectFit Plus Plan *(Accidental Injury Only Insurance Policy Form CH-26110-IP (06/09), or its state variation):*
[☐ High Option FPRH] [☐ Low Option FPRL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[HospitalFit Plus Plan *(Hospital and Surgical Indemnity Policy Form CH-26111-IP (06/09), or its state variation):*
[☐ High Option FPIH] [☐ Low Option FPIL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[PersonalFit Plus Plan *(Sickness-only Scheduled Indemnity Policy Form CH-26112-IP (06/09), or its state variation):*
[☐ High Option FPEH] [☐ Low Option FPEL] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[[CancerWise ECA1 *(Cancer Benefit Policy Form CH-26055-IP (5/07), or its state variation):* Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
First Diagnosis Cancer Benefit Amount: [☐ $20,000] [☐ $30,000] [☐ $40,000] [☐ $50,000]]

[Critical Illness Direct CIIC *(Specified Disease/Condition and Major Organ Transplant Policy Form CH-26113-IP (01/10), or its state variation)*:

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000] [☐ $70,000] [☐ $80,000] [☐ $90,000] [☐ $100,000]]

[Critical Accident Direct CAIC *(Critical Accidental Injury Policy Form CH-26123-IP (04/11), or its state variation):*

Lifetime Maximum Benefit Amount: Applicant ☐1
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant ☐2
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]

Lifetime Maximum Benefit Amount: Applicant(s): ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000] [☐ $30,000] [☐ $40,000]
[☐ $50,000] [☐ $60,000]]

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APPLICATION FOR POLICIES UNDERWRITTEN BY
THE CHESAPEAKE LIFE INSURANCE COMPANY

[SECTION 1 -] DEMOGRAPHICS AND INSURANCE COVERAGE SELECTIONS

[Accident Disability Direct DSIC *(Accident-only Disability Income Insurance Policy Form CH-26114-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Income Protection Direct DIIC *(Disability Income Insurance Policy Form CH-26115-IP (01/10), or its state variation):*

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐1
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]

Monthly Indemnity Benefit: [☐ $500] [☐ $1,000] [☐ $1,500] [☐ $2,000] [☐ $2,500] Applicant ☐2
Elimination Period: [☐ 14 Days] [☐ 30 Days]
Duration: [☐ 6 Months] [☐ 12 Months] [☐ 18 Months] [☐ 24 Months]]

[Hospital Confinement Direct DBIC *(Hospital Confinement Indemnity Policy Form CH-26116-IP (01/10), or its state variation):*

Daily Benefit Amount: [☐ $250] [☐ $500] [☐ $750] [☐ $1,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

[Accident Direct ACLC *(Accidental Injury Only Insurance Policy Form CH-26118-IP (01/10), or its state variation):*

Maximum Accidental Injury Benefit Amount: Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8
[☐ $5,000] [☐ $10,000] [☐ $15,000] [☐ $20,000] [☐ $25,000]]

[Accident Companion AGLC *(Accidental Injury Only Insurance Policy Form CH-26122-IP (01/11), or its state variation):*

[☐ Level $2,500] [☐ Level $5,000] [☐ Level $7,500] [☐ Level $10,000] Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8]

If applying for [PROTECTFIT PLUS PLAN,] [CRITICAL ACCIDENT DIRECT,] [ACCIDENT DIRECT,] [ACCIDENT COMPANION,] [VISION PLAN] and/or [DENTAL PLAN] ONLY, please proceed to [SECTION 9].

[SECTION 2 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DIRECT BUNDLE]
[♦ ACCIDENT DISABILITY DIRECT]
[♦ COMPLETE DIRECT BUNDLE]
[♦ INCOME PROTECTION DIRECT]

1. (a) Occupation/duties of Primary Applicant: _____ ☐ Blue Collar ☐ White Collar

(Complete if applying for Spouse)
(b) Occupation/duties of Spouse Applicant: _____ ☐ Blue Collar ☐ White Collar

If applying for [ACCIDENT DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 3 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ COMPLETE DIRECT BUNDLE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITAL DIRECT BUNDLE]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

2. Within the past 60 days has any Applicant had any abnormal diagnostic test results or unexplained weight loss, or been advised by a Physician to have any testing or treatment which has not yet occurred, for which results are still pending, and/or that requires follow-up that has not been completed? ☐ Yes ☐ No

If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

If applying for [COMPLETE DIRECT BUNDLE,] [HOSPITAL DIRECT BUNDLE,] ONLY, please proceed to [SECTION 9].

[SECTION 4 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]

Family History:

3. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had any form of cancer (other than skin cancer) prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 5 -] APPLICABLE TO THE FOLLOWING PLAN ONLY:

[♦ CRITICAL ILLNESS DIRECT]

Family History:

4. Does any Applicant have two or more immediate family members (biological parents or siblings), living or deceased, who have had Heart Disease, Stroke, Diabetes (type I), Kidney Disease, Liver Disease, Alzheimer's or Senile Dementia prior to age 65? ☐ Yes ☐ No

If any "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

[SECTION 6 -] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CANCERWISE]
[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

5. Has any Applicant ever been diagnosed, received medical advice to be tested, hospitalized, treated, or been treated for melanoma, cancer, Hodgkin's Disease, non-Hodgkin's Lymphoma, leukemia or other malignant growths or tumors? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

6. Has any Applicant been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex, or tested positive for Human Immunodeficiency Virus (HIV) or an AIDS-related test? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [CANCERWISE] ONLY, please proceed to [SECTION 9].

[SECTION 7 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ CRITICAL ILLNESS DIRECT]
[♦ HOSPITAL CONFINEMENT DIRECT]
[♦ HOSPITALFIT PLUS]
[♦ INCOME PROTECTION DIRECT]
[♦ PERSONALFIT PLUS]

7. Within in the last three years, has any Applicant been prescribed medication for more than one month (other than sleep aids, contraceptives, antibiotics or any medication to treat allergies, situational depression/anxiety, migraines, ADD/ADHD, thyroid conditions or heart burn/acid reflux)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8

8. Does any Applicant require human assistance of any kind to perform activities of daily living (bathing, dressing, continence, eating, or using the toilet)? ☐ Yes ☐ No
   If "Yes," indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

9. Has any Applicant had symptoms, been diagnosed, received medical advice to be tested, hospitalized or treated, or been treated for ***any*** of the following:

(a) Uncontrolled cholesterol or uncontrolled blood pressure, within the last 6 months?	☐ Yes ☐ No	(d) Kidney failure or abnormal kidney functions (excludes kidney stones), within the last 10 years?	☐ Yes ☐ No
(b) Substance abuse, bipolar, major depressive, or psychotic disorder, within the last 3 years?	☐ Yes ☐ No	(e) Diabetes (type I or II), within the last 10 years?	☐ Yes ☐ No
(c) Heart disorder or disease, heart attack, stroke or mini-stroke (including transient ischemic attack), within the last 10 years?	☐ Yes ☐ No	(f) Organ transplant	☐ Yes ☐ No

If "Yes" to any of the above, indicate Applicant(s): ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If applying for [HOSPITALFIT PLUS,][PERSONALFIT PLUS,][CRITICAL ILLNESS DIRECT,][HOSPITAL CONFINEMENT DIRECT] ONLY, please proceed to [SECTION 9].

[SECTION 8 –] APPLICABLE TO THE FOLLOWING PLANS ONLY:

[♦ ACCIDENT DISABILITY DIRECT] ***[♦ INCOME PROTECTION DIRECT]***

10. Has any Applicant ever been convicted of any felony activity? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

11. (a) Within the last 12 months, has the Primary Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

    (Complete if applying for Spouse)
    (b) Within the last 12 months, has the Spouse Applicant been unemployed for more than one month or consistently worked less than 25 hours per week? ☐ Yes ☐ No

12. (a) What is the Primary Applicant's annual gross income from the occupation/duties previously listed? $_____

    (Complete if applying for Spouse)
    (b) What is the Spouse Applicant's annual gross income from the occupation/duties previously listed? $_____

13. In the last five years has any Applicant been hospitalized or had surgery for spine, neck or back, or surgical joint repair or replacement? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

14. Has any Applicant currently or within the last 5 years filed a claim or received benefits from any disability insurance or salary continuation plan for disability *(other than pregnancy)?* ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

15. Has any Applicant had symptoms, been diagnosed, received medical advice or been treated for sleep apnea, fibromyalgia, Parkinson's, chronic fatigue syndrome, unresolved carpal tunnel syndrome, rheumatoid arthritis, or Epstein Barr, within the last 12 months? ☐ Yes ☐ No
    If "Yes," indicate Applicant(s): ☐ 1 ☐ 2

Please proceed to [SECTION 9].

[SECTION 9 –] APPLICABLE TO ALL PLANS

BILLING INFORMATION

Initial Payment: ☐ACH (Auth Section Required) [☐Credit Card] [☐Direct Pay] [☐Payroll Deduction]	Bill Type: ☐ACH (Auth Section Required) [☐Credit Card] [☐ Direct Bill]
☐ Individual Billing / Mode: (If applicable) ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	[☐ Payroll Deduction / Mode: (If applicable) ☐ Weekly ☐ Bi-weekly ☐ Semi-monthly ☐ Monthly]
☐ Single ☐ Primary and Spouse ☐ Primary and Child(ren) ☐ Family	Relationship of Payor to Primary Applicant: ☐ Self ☐ Parent/Guardian ☐ Other If "Other" who, and reason for such:_____
[Preferred Draft Date: _____]	[Requested Effective Date of Coverage: _____ (cannot be the 29th, 30th; or 31st of any given month)]
Premium Amount quoted [(including $[20] one-time application fee)]: $_____ Check #: _____(if collected at sale)	[Special Request(s):_____]

DECLARATIONS AND AGREEMENTS

I agree that: (a) all statements and answers in this Application are true to the best of my knowledge and belief; (b) this Application will form a part of the contract; (c) no insurance will take effect unless and until the Application is approved by the Company and the Policy is delivered to the Applicant ***while the conditions affecting the insurability are and have remained as described herein and the first premium has been paid in full***.

If this application was solicited by an agent, I understand that the agent does not have the authority on behalf of the Company to accept the risks, or to make, alter or amend the coverage or to extend the time for making any payment due on such coverage.

I understand that the [Hospital Confinement Direct Policy] [and the Income Protection Direct Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *one year* after the Effective Date of Coverage [and that the [HospitalFit Plus Policy] [and the PersonalFit Plus Policy] do[es] not provide benefits for any loss resulting from a Pre-Existing Condition, unless the loss is incurred at least *six months* after the Effective Date of Coverage.

I further understand that these products are intended as a supplement to and not a substitute for comprehensive health insurance.

INSURANCE FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and is subject to criminal and/or civil penalties.

Signed _____/_____/_____ at _____, _____
Date City State

X_____ X_____
Signature of Primary Applicant Signature of Spouse Applicant (If to be covered)

TO BE ANSWERED BY AGENT FOR AGENT SOLICITED APPLICATIONS:
Each question on this application was answered and documented by the Applicant(s) named above. ☐
-OR-
I, the Agent, certify that each question on this application was asked by me of the Applicant(s) named above, and all answers were accurately documented. ☐

X _____
Signature of Licensed Agent Print Full Name Agent Number